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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JULIE RENEE NAJAR,** **AKA JULIE RENEE ALMQUIST,** **AKA JULIE RENEE NELSON,** **AKA JULIE RENEE PHILLIPS** **26304 Chatsworth Court** **Sun City, CA 92586** **Registered Nurse License No. 476881** Respondent.	Case No. 2013-318 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1992, the Board of Registered Nursing issued Registered Nurse License Number 476881 to Julie Renee Najar, aka Julie Renee Almquist, aka Julie Renee Nelson, and aka Julie Renee Phillips (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761(a) of the Code provides that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
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> . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. Methamphetamine is a stimulant used for the treatment of attention deficit hyperactivity disorder (ADHD) and obesity, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(d)(2), and is a dangerous drug pursuant to Code section 4022.

10. Adderall is a brand name for amphetamines used to treat hyperactivity disorder (ADHD), and is a Schedule II controlled substance as designated by Health and Safety Code section 11055(d)(1) and is a dangerous drug pursuant to Code section 4022.

11. Oxycodone/acetaminophen is a Schedule II controlled substance used to treat pain as designated by Health and Safety Code section 11055(b)(1)(M) and a dangerous drug pursuant to Code section 4022.

12. Fentanyl is an opiate analgesic used to treat break through pain in cancer patients, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(8), and a dangerous drug pursuant to Code section 4022.

13. Dilaudid is a brand name for hydromorphone used to treat moderate to severe pain, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(J), and is a dangerous drug pursuant to Code section 4022.

14. Morphine is an opiate analgesic used to treat moderate to severe pain, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(L), and a dangerous drug pursuant to Code section 4022.

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15. Norco is a brand name for hydrocodone bitartrate and acetaminophen used to treat pain, is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(3), and is a dangerous drug pursuant to Code section 4022.

16. Vicodin is a brand name for hydrocodone and acetaminophen used to treat pain, is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4) and is a dangerous drug pursuant to Code section 4022.

17. Ativan is a brand name for lorazepam used to treat anxiety, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(16) and is a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Theft of Narcotics)

18. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a) of the Code in that Respondent diverted dangerous drugs and controlled substances from Eisenhower Medical Center, in Rancho Mirage, California for her own personal use between January of 2009 and April of 2009. The circumstances are set forth below.

EISENHOWER MEDICAL CENTER (EMC)

19. On March 31, 2008, Respondent was hired as a charge nurse at EMC in the Emergency Department. She was terminated from EMC on May 13, 2009 when an investigation by hospital staff revealed that Respondent was diverting Scheduled II and III controlled substances. Nursing staff at EMC reviewed Acudose Reports[1] and narcotic administration logs during Respondent's shifts between January 1, 2009 and April 26, 2009, which revealed the following:

[1] Acudose (manufactured by CareFusion) is the trade name for the automated single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a "user ID" code to operate the control panel. The user is required to enter a second code "PIN" number, similar to an ATM machine, to gain access to the medications. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as wastage. This waste must be witnessed by another authorized user and is also recorded by the Acudose machine.

Patient #424 Eisenhower Medical Center

20. On January 1, 2009, Patient #424 arrived at the EMC Emergency Department complaining of lower left quadrant pain that began a week earlier. The patient's physician ordered hydromorphone injectable 1 mg IV to be administered one time at 12:43 p.m. and one time at 1:33 p.m. Respondent removed 1 mg of hydromorphone injectable IV from the Acudose machine four times, at 11:08 a.m., 12:06 p.m., 1:35 p.m. and 1:37 p.m. for Patient #424. Respondent documented administering a one mg dose of hydromorphone IV at 12:28 a.m., prior to the time the order was placed at 12:43 p.m., and failed to account for the extra 3 mg of hydromorphone.

Patient #578 Eisenhower Medical Center

21. On January 7, 2009, Patient #578 arrived at the EMC Emergency Department with a fractured ankle from falling off of a truck. Patient #578's ankle was placed in a splint and he was sent home. The following day, on January 8, 2009, Patient #578 arrived at the EMC Emergency Department due to being physically assaulted. The Patient's physician ordered lorazepam 1 mg IV to be administered once at 3:00 p.m. Respondent removed 2 mg of lorazepam at 3:28, and documented administering one 1mg IV at 3:30 p.m. Respondent failed to account for the extra mg of lorazepam. Further, at 4:36 p.m. Respondent removed 2 mg of hydromorphone injectable for this patient from the Acudose machine without a doctor's order. Respondent did not document administering the hydromorphone or that it was wasted. Respondent failed to account for 2 mg of hydromorphone and 1 mg of lorazepam.

Patient #019 Eisenhower Medical Center

22. On January 8, 2009, Patient #019 was found unconscious at the nursing home where he lived and was brought by ambulance to the EMC Emergency Department. His physician ordered 2 tablets of Vicodin 5/325 to be given once at 8:46 a.m. At 8:53 a.m., Respondent removed one tablet of oxycodone-acetaminophen 5/325 from the Acudose machine for this patient, but did not document administering this medication or wasting it. Approximately 20 minutes later at 9:06 a.m., Respondent removed one tablet of hydrocodone-acetaminophen 5/325 from the Acudose

machine and documented giving 2 tablets of this medication to Patient #019 at 9:10 a.m. Respondent failed to account for 1 tablet of oxycodone-acetaminophen 5/325.

Patient #020 Eisenhower Medical Center

23. On January 10, 2009, Patient #020 walked into the EMC Emergency Department complaining of severe abdominal pain. The patient's physician prescribed hydromorphone 1 mg IV to be given one time at 7:00 a.m. Respondent withdrew hydromorphone 1 mg injectable from the Acudose machine at 7:15 a.m. and documented administering this medication at 7:26 a.m. however this Patient was not assigned to Respondent.

Patient #023 Eisenhower Medical Center

24. On January 10, 2009, Patient #023 arrived at EMC Emergency Department complaining of left side flank and back pain with vomiting. The patient's physician ordered hydromorphone injectable 1 mg IV to be given three times at 7:29 a.m., 8:14 a.m. and 11:18 a.m. Respondent removed a fourth dose of hydromorphone 1 mg injectable at 10:33 a.m. without a doctor's order and failed to waste it. Respondent failed to account for 1 mg of hydromorphone.

Patient #049 at Eisenhower Medical Center

25. On January 13, 2009, Patient #049 arrived at the EMC Emergency Department via ambulance with a complaint of feeling weak and dizzy. Patient #843's physician ordered one tablet of Vicodin 5/325 to be administered one time at 12:39 p.m. The Acudose Report documented that Respondent removed one Vicodin tablet at 12:41 p.m. but she failed to document administering the medication. Respondent failed to account for 1 tablet of Vicodin.

Patient #069 Eisenhower Medical Center

26. On January 13, 2009, Patient #069 developed severe abdominal pain with vomiting following a liver biopsy. The patient's physician ordered hydromorphone injectable 1 mg IV to be administered one time at 6:27 p.m. At 6:50 p.m. Respondent removed 2 mg of hydromorphone from the Acudose machine and documented administering one mg of hydromorphone at 7:00 p.m. Respondent failed to account for the extra 1 mg. of hydromorphone.

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Patient #074 at Eisenhower Medical Center

27. On January 13, 2009, Patient #074 was seen at the EMC Emergency Department due to complaints of abdominal pain. His physician ordered 2 mg of morphine IV to be administered once at 9:25 a.m., and 4 mg of Morphine IV to be administered once at 2:08 p.m. Respondent removed 2 mg of morphine for Patient #074 at 9:26 a.m. and documented administering this medication at 9:40 a.m. Respondent removed 4 mg of morphine IV at 2:01 p.m., but there is no record that it was administered or wasted. Respondent failed to account for 4 mg of morphine IV.

Patient #841 Eisenhower Medical Center

28. On January 14, 2009, Patient #841 entered the EMC Emergency Department complaining of chest pain that began eight hours earlier. The patient's physician's ordered morphine injectable 4 mg IV to be administered once at 5:37 p.m. This order was cancelled at 6:07 p.m., and a new order for hydromorphone injectable 1 mg IV was ordered to be administered one time at 6:07 p.m. Respondent removed 4 mg of morphine at 6:02 p.m. but failed to document wasting the medication. At 6:23 p.m., Respondent removed 1 mg of hydromorphone IV and documented administering it at 6:15 p.m., prior to the time she withdrew it from the Acudose machine. Respondent failed to account for 4 mg of morphine.

Patient #216 Eisenhower Medical Center

29. On January 14, 2009, 91-year old Patient #216 was brought to the EMC Emergency Department with sharp stabbing abdominal pain and an inability to urinate. Among other medications, the patient's physician ordered hydromorphone injectable 1 mg IV to be administered once at 7:39 p.m. Respondent removed 1 mg hydromorphone injectable at 5:35 p.m. without a doctor's order. There was no record of the disposition of this medication. Respondent failed to account for 1 mg of hydromorphone.

Patient #087 Eisenhower Medical Center

30. On January 16, 2009, Patient #087, an 82-year old male, presented at the EMC Emergency Department with complaints of nausea, vomiting and diarrhea over the previous 3 days. The patient's physician ordered hydromorphone injectable 1 mg IV to be administered one time at 12:41 p.m. Respondent removed 1 mg of hydromorphone injectable IV at 11:17 a.m.

without a doctor's order and without documenting that the medication was administered. Respondent failed to account for 1 mg of hydromorphone.

Patient #023 Eisenhower Medical Center

31. On January 22, 2009, Patient #023 arrived at the EMC Emergency Department complaining of vomiting black emesis and abdominal pain following a reversed colostomy performed three days earlier. The patient's physician ordered morphine injectable 4 mg IV to be given once to Patient #023 at 7:27 a.m. After administering the dose, Respondent removed a second 4 mg of morphine injectable IV at 9:34 a.m. without a doctor's order and did not record the disposition of the medication. Respondent failed to account for 4 mg of morphine.

Patient #030 Eisenhower Medical Center

32. On January 25, 2009, Patient #030 arrived at the EMC Emergency Department complaining of chest pain over the last three days. Her physician ordered Fentanyl 50 mcg IV to be administered once at 10:33 a.m. and a second dose at 11:21 a.m. At 10:58 a.m., Respondent removed 100 mcg of Fentanyl for Patient #030, and documented administering 50 mcg, but failed to account for the remaining 50 mcg of Fentanyl. At 11:19 a.m. Respondent removed Fentanyl 100 mcg for Patient #030, but documented administering 50 mcg. Respondent failed to account for or waste the remaining 50 mcg of Fentanyl. In total, Respondent failed to account for 100 mcg of Fentanyl.

Patient #171 Eisenhower Medical Center

33. On February 17, 2009, Patient #171 came to the EMC Emergency Department complaining of back pain interfering with her ability to walk. The patient's physician ordered hydromorphone injectable 0.5 mg IV to be administered once at 9:01 a.m. and once at 12:08 p.m. Respondent removed 1 mg of hydromorphone at 9:08 a.m., and documented administering 0.5 mg at 9:20 a.m., but she failed to account for the remaining 0.5 mg. Respondent removed hydromorphone injectable 1 mg IV at 10:54 a.m. and failed to document the administration of the medication or that it had been wasted. At 2:32 p.m., Respondent removed hydromorphone injectable 1 mg IV and documented administering 0.5 mg at 2:32 p.m. without a doctor's order.

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Respondent failed to account for 2 mg of hydromorphone she removed from the Acudose machine. The 10:54 a.m. and 2:32 p.m. withdrawals were made without a physician's order.

Patient #528 Eisenhower Medical Center

34. On February 26, 2009, Patient #528 came to EMC Emergency Department complaining of left shoulder, chest and rib pain with fever and swollen left neck lymph nodes. Her physician prescribed hydromorphone injectable 1 mg IV once at 3:12 p.m., once at 3:54 p.m. and once at 5:06 p.m. Respondent removed 5 mg. of hydromorphone for this patient from the Acudose machine, documented administering 3 mg but failed to account for the remaining 2 mg. of hydromorphone.

Patient #036 Eisenhower Medical Center

35. On March 5, 2009, Patient #036 came to the EMC Emergency Department complaining of sharp, stabbing abdominal pain with mild chest burning and vomiting. The patient's physician prescribed hydromorphone injectable 0.5 mg IV to be administered once at 8:01 a.m. Respondent removed hydromorphone 1 mg injectable at 8:03 a.m., documented administering 0.5 mg, but failed to account for the remaining 0.5 mg. At 9:18 a.m., Respondent removed 1 mg of hydromorphone injectable without a physician's order. In total, Respondent failed to account for 1.5 mg of hydromorphone.

Patient #117 Eisenhower Medical Center

36. On March 7, 2013, Patient #117 was seen in the EMC Emergency Department complaining of right lower back and flank pain. Patient #117's physician ordered one injection of hydromorphone 1 mg IV to be administered at 6:08 p.m., but the patient refused the medication. Nevertheless, Respondent pulled hydromorphone 1 mg injectable from the Acudose machine for this patient at 6:53 p.m. and did not document wasting this medication. Moreover, this patient was not assigned to Respondent. Respondent failed to account for 1 mg of hydromorphone.

Patient #464 at Eisenhower Medical Center

37. On March 13, 2009, Patient #464 presented at the EMC Emergency Department with complaints of chest pain. Her physician ordered a single injection of 6 mg of morphine IV to be administered at 7:31 p.m., which was immediately cancelled because the patient refused the

medication. The Acudose Report states that Respondent removed morphine injectable 10 mg IV at 5:16 p.m., 2 hours before it was ordered. There is no documentation that this medication was wasted. Respondent failed to account for 10 mg of morphine.

Patient #155 Eisenhower Medical Center

38. On April 5, 2009, Patient #155 presented for the second time that day to the EMC Emergency Department complaining of chronic pain in the left arm and shoulder. The patient's physician prescribed hydromorphone oral 2 mg to be administered one time at 6:31 p.m. This order was cancelled at 6:31 p.m.. The patient's physician ordered hydromorphone injectable 2 mg IV, to be administered one time at 7:00 p.m. Respondent removed 4 mg of injectable hydromorphone for this patient from the Acudose machine at 7:02 p.m. Respondent documented administering 2 mg of the hydromorphone, but failed to account for the remaining 2 mg of hydromorphone.

Patient #061 Eisenhower Medical Center

39. On April 26, 2009, Patient #061 presented to the EMC Emergency Department following a slip and fall at her home. She was unable to get up off the floor so she called 911. Her physician ordered hydromorphone injectable 1 mg IM to be given one time at 11:27 a.m. At 11:28 a.m., Respondent removed 2 mg hydromorphone injectable IM, and documented administering 1 mg, but failed to waste or account for the remaining 1 mg of hydromorphone. At 2:06 p.m., Respondent removed an additional 2 mg of hydromorphone from the Acudose machine without a physician's order. She failed to account for 3 mg of hydromorphone.

40. Respondent's supervisor at EMC told the Board's investigator that Respondent was reportedly acting strangely and was not focused on several occasions during her employment at EMC. Consequently, Respondent was placed on two performance improvement plans in an effort to assist her, but to no avail.

41. On June 3, 2009, the Chief Nursing Officer at EMC filed a complaint with the Board regarding Respondent's diversion of drugs from their facility.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Illegal Possession of Narcotics and/or Dangerous Drugs)

42. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(a) of the Code in that Respondent obtained or possessed in violation of law, controlled substances or dangerous drugs as set forth above in paragraphs 19 through 39.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Falsification of Hospital Records Regarding Narcotics and/or Dangerous Drugs)

43. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(e) of the Code in that Respondent made false, grossly incorrect, and/or grossly inconsistent entries in hospital, or patient charts pertaining to the administration of controlled substances and/or dangerous drugs, by failing to document the administration of drugs, or falsely documenting that she administered drugs to patients when she did not, or by obtaining dangerous drugs without a physician's order, as set forth above in paragraphs 19 through 39.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Illegal Use of Narcotics and/or Dangerous Drugs)

44. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(b) of the Code in that Respondent used controlled substances or dangerous drugs, or alcoholic beverages, to an extent or in a manner dangerous or injurious to herself, any other person, or to the public. The circumstances are set forth below.

KAISER PERMANENTE ANAHEIM, CALIFORNIA (KPA)

45. Respondent was employed at KPA from November 29, 2010 through August 25, 2011 in the Emergency Department. On May 19-20, 2011, Respondent was working the 3:00 p.m. to 3:00 a.m. shift in the Emergency Department at KPA. During her shift, she was observed to be jittery, sweaty, jerky in her movements, unsteady on her feet and acting erratically. At 1:00 a.m., her supervisor made the decision to send her home because Respondent was not safe to have patient care responsibilities. Respondent agreed to leave, but did not leave the hospital. Between 1:00 a.m. and 4:00 a.m. Respondent was very emotional, sobbing uncontrollably with erratic

movements and pacing with an unsteady gait. At around 2:30 a.m. Respondent barricaded herself in the radiology bathroom and the house supervisor spent 30 minutes talking to Respondent and was able to talk her out of the bathroom. At approximately 3:20 a.m., Respondent locked herself in the x-ray lobby restroom and refused to come out. Staff members heard banging, cursing and mumbled speech. Security officers forced the door open and removed Respondent. At this point, Respondent agreed to be evaluated in the Emergency Department and was admitted to the hospital and released several days later. Respondent was then on medical leave from KPA until she returned to work on August 20, 2011. On this date, she was placed on paid administrative leave pending the outcome of an investigation. On August 25, 2011, an investigatory meeting was held with Respondent where she presented her resignation letter to hospital management. Therefore, no further investigation was conducted by the hospital into the events of May 19-20, 2011.

46. Respondent signed a release for her medical records from KPA. A review of Respondent's medical records from May 20-31, 2011, revealed that she had been using methamphetamine and Vicodin. She gave a history of Vicodin use, 1-2 pills, two times per week for the past 2 weeks, Ultram, 3-4 tablets daily for the past 5 years, and crystal methamphetamine, orally 3 lines in two days, and binge use. A drug screen taken on May 20, 2011 was positive for amphetamines and hydromorphone. Respondent's physician attributed her behavior on May 19-20, 2011 to her methamphetamine and hydromorphone abuse. Respondent provided an extensive drug abuse history to the physician. Respondent admitted forging a prescription in the past and that she was fired from other nursing positions due to suspicions of drug use, that she is an alcoholic, and that she lost custody of her 8-year old daughter due to Vicodin abuse. Her daughter was 15 years old at the time of her hospitalization at KPA. Respondent stated that she had been through approximately five detoxification programs in San Diego, but none helped.

47. On May 3, 2012, Respondent met with the Board's investigator and admitted to obtaining and using methamphetamine on May 20, 2011 and that she was probably impaired on May 19-20, 2011, due to insomnia. She also admitted to diverting Dilaudid in the past.

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Respondent also agreed to provide the investigator with a urine sample for a voluntary drug screen. A urine sample was collected.

48. On May 5, 2012, the drug screen results on Respondent were positive for amphetamines, and for opiates. Respondent said she had a prescription for Adderall and submitted a copy of a prescription that was not readable.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 476881, issued to Julie Renee Najar, aka Julie Renee Almquist, aka Julie Renee Nelson, aka Julie Renee Phillips;

2. Ordering Julie Renee Najar aka Julie Renee Almquist, aka Julie Renee Nelson, aka Julie Renee Phillips to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: October 25, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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